Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4673HIC	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLICER RESIDENTIAL CARE	3861 CLIMBING ROSE STREET LAS VEGAS, NV 89147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initial Comments This Statement of Deficiencies was generated as a result of a complaint survey conducted Between 2/19/10 and 2/25/10. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00023834 was substantiated. See Tag H019. The following regulatory deficiencies were identified:	H 000		
H 019	Director Duties-No FA/CPR NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has been trained in first aid, and cardiopulmonary resuscitation, is on the premises of the home at all times when a resident is present. This Regulation is not met as evidenced by: Based on record review and staff interviews 2/19/10 through 2/23/10, the director did not ensure that 1 of 2 caregivers had received training in cardiopulmonary resuscitation (CPR) and first aid (Employee #2). The provider listed	H 019		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4673HIC	A. BUILDING _____ B. WING _____	C 02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLICER RESIDENTIAL CARE	**3861 CLIMBING ROSE STREET LAS VEGAS, NV 89147**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 019	Continued From page 1 on the CPR card, Medic One Inc., was unable to verify Employee #2 had participated in CPR and First Aid training on the dates listed on the card.	H 019		